

INFORMED CONSENT TO CHIROPRACTIC CARE

Donna J. Stackpool, D. C.

Patient: Please discuss any questions or concerns with the Doctor before signing this consent.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments. Alternative types of care have been reviewed.

Though chiropractic adjustments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to adjustments. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations and sprains.

I understand that I will be receiving my care in an open room setting.

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic adjustment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction.

Signature of Patient _____ Date _____

Signature of Parent/Guardian _____ Date _____
(If patient is a minor)